Polyendocrine metabolic ovarian syndrome, the new name for polycystic ovary syndrome: a multistep global consensus process

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Polyendocrine metabolic ovarian syndrome (PMOS), previously named polycystic ovary syndrome (PCOS), affects one in eight women. However, the term PCOS is inaccurate, implying pathological ovarian cysts, obscuring diverse endocrine and metabolic features, and contributing to delayed diagnosis, fragmented care, and stigma, while curtailing research and policy framing. Building on an international mandate for change, we outline an unprecedented, rigorous, multistep global consensus process for the name change. Funding and governance were established with engagement of 56 leading academic, clinical, and patient organisations. Using iterative global surveys (with responses from 14 360 people with PCOS and multidisciplinary health professionals from all world regions), modified Delphi methods, nominal group technique workshops, and marketing and implementation analyses, we identified principles prioritising scientific accuracy, clarity, stigma avoidance, cultural appropriateness, and implementation feasibility. An accurate new name was prioritised over retaining the PCOS acronym or a generic name. Implementation approaches prioritised evolution rather than transformation. Preferred terms were polyendocrine, metabolic, and ovarian, reflecting the condition's multisystem pathophysiology, and polyendocrine metabolic ovarian syndrome was the consensus new name. Accuracy was improved by omitting cysts and by capturing endocrine, metabolic, and ovarian dysfunction. A co-designed global implementation strategy, including a transition period, education, and alignment with health systems and disease classification, is under way.

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Background and rationale

Polycystic ovary syndrome (PCOS) affects 170 million women during their reproductive years alone.[1] Following exclusion of other disorders, the condition is diagnosed based on adults (aged ≥20 years) meeting at least two of the following International Guideline criteria: (1) oligo-anovulation, (2) clinical or biochemical hyperandrogenism, and (3) polycystic ovaries on ultrasound or elevated anti-Müllerian hormone (AMH).[2,3] Adolescents (aged 10–19 years) require the presence of the first two criteria.[4] PCOS has long been primarily perceived as a gynaecological or ovarian disorder; however, mounting research, evidence synthesis, and International Guidelines have shown that PCOS is underpinned by endocrine disturbances in insulin, androgens, and neuroendocrine and ovarian hormones.[2–5] Features can be metabolic (ie, obesity, dysglycaemia, type 2 diabetes, hypertension, dyslipidaemia, metabolic dysfunction-associated steatotic liver disease, cardiovascular disease, and sleep apnoea), reproductive (ovulatory disturbances, irregular menstrual cycles, infertility, pregnancy complications, and endometrial cancer), psychological (depression, anxiety, poor quality of life, and eating disorders), and dermatological (acne, alopecia, and hirsutism).[2–5] BMI is generally higher in people with PCOS than in those without the condition, and contributes to its severity.[6] Overall, PCOS has multisystem health impacts and represents a growing health and economic burden.[1,7]

However, the broad clinical features of the condition are not captured in its current name, as although arrested follicular development is common, pathological ovarian cysts are not increased.[8–10] These factors delay diagnosis—with up to 70% of affected individuals remaining undiagnosed—and also contribute to widespread knowledge gaps and patient dissatisfaction.[11–13] In 2012, the US National Institutes of Health Office of Disease Prevention Evidence-based Methodology Workshop on

Key messages

- Polycystic ovary syndrome affects more than 170 million women globally, yet its current name is inaccurate and misleading, obscuring the condition's multisystem endocrine and metabolic features, reinforcing stigma, delaying diagnosis, and hindering effective clinical care, research, and policy alignment.
- Through an unprecedented, rigorous global consensus process engaging patients, multidisciplinary health professionals, and organisations across world regions, a new name—polyendocrine metabolic ovarian syndrome—was agreed, omitting the misleading reference to ovarian cysts and accurately reflecting the diverse features of the condition.
- Consensus for the new name was built by use of robust, transparent methods, including modified Delphi survey processes, nominal group technique workshops, and implementation and marketing analyses, ensuring scientific accuracy, cultural appropriateness, stigma avoidance, and feasibility of adoption. These processes optimised representativeness, legitimacy, and transparency, and served to enhance engagement to underpin implementation.
- Coordinated implementation is under way in health systems, research institutions, funding bodies, education providers, clinical guidelines, and disease classification systems (including ICD coding), and is supported by a global transition period and continuous evaluation.
- Aligning nomenclature with scientific evolution and improving accuracy will enhance awareness, diagnosis, care quality, research coherence, and patient experience, strengthening policy, advocacy, and health outcomes globally.

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PCOS highlighted the challenges and inaccuracy of the current name, and recommended a change to better reflect the condition.[14] Despite the strong rationale (panel 1) and long-standing recognition that PCOS is an inaccurate and misleading term, efforts to change the name have repeatedly stalled. Patient groups, alongside leaders in the field of reproductive medicine, such as Dr Ricardo Azziz, Prof Andrea Dunaif, Prof Bart CJM Fauser, Prof Robert J Norman, and Prof Helena J Teede, have persistently advocated for change.[8,9,15,16] Expert commentaries, guidelines, and surveys have reaffirmed the limitations of the narrow reproductive focus and inaccuracies, noting ongoing confusion among people with PCOS and clinicians, fragmented policy and advocacy efforts, and downstream consequences for diagnosis, care, outcomes, and research.[2,8,9,15] However, previous renaming efforts failed to gain traction, with barriers including a lack of inclusive global leadership and the need for a coordinated international consensus process, alignment between patient advocacy groups, agreement on an alternative name, and a comprehensive implementation strategy.[8,9] The need for greater awareness, advocacy, education, and implementation, alongside international collaboration and resourcing, was also recognised.[9] A longitudinal global study engaged people with PCOS and health professionals in serial surveys and workshops and highlighted ongoing confusion around the name.[9] Overall, 84% of respondents endorsed a global consensus process to identify and implement a new name, alongside education and implementation strategies. An accompanying impact assessment indicated that the perceived benefits of a name change outweighed the risks.[9] As a result of these data, the compelling evidence base, and strong patient advocacy and leadership by Verity, a UK-based charity and advocacy organisation, Monash University's Centre for Research Excellence in Women's Health in Reproductive Life and the Androgen Excess and PCOS Society launched a global initiative with a clear mandate for a name change.[9]

Throughout this process, we sought to obtain funding; establish governance; further engage people with PCOS, multidisciplinary health professionals, and their member organisations across world regions; and undertake global surveys and workshops through modified Delphi and nominal group techniques. We aimed to establish principles, approaches, preferred terms, a new name, and implementation priorities.[9] Ultimately, this Health Policy initiative outlines both the consensus process and a pragmatic global implementation strategy to correct inaccuracies, recognise diverse clinical features of the condition, and strengthen research, education, and clinical care to improve health outcomes globally for people with polyendocrine metabolic ovarian syndrome (PMOS).

***Panel 1*: Context and the case for a new name**

The term polycystic ovary syndrome (PCOS) has long been recognised as inaccurate and potentially harmful. The following evidence-based considerations informed the need for a new name:

- The term polycystic ovary implies the presence of pathological ovarian cysts, which are not a feature of the condition. This misnomer contributes to misunderstandings among patients, clinicians, policy makers, and the public.
- PCOS encompasses diverse endocrine, metabolic, reproductive, psychological, and dermatological features. The current name reflects only one organ and fails to capture the disorder's multisystem nature.
- Confusion arising from the current name can delay diagnosis and hinder effective communication between patients and health professionals, contributing to patient dissatisfaction with care.
- The reproductive focus of the name can reinforce stigma, particularly in sociocultural contexts where fertility carries high value. Many individuals report distress associated with the name itself.
- The misnomer complicates epidemiological classification, research comparability, and health system coding. A more accurate name is expected to improve scientific coherence, research funding, and policy alignment.
- International guidelines, expert groups, and patient organisations have repeatedly called for renaming, with serial surveys and workshops culminating in a mandate to change the name through a rigorous, global consensus process.
- A new name must support long-term clinical care, research, and global adoption, and enable a smooth transition from existing terminology.

Global engagement and processes

The Australian National Health and Medical Research Council awarded funding to the Centre for Research Excellence in Women's Health in Reproductive Life, which provided leadership alongside the Androgen Excess and PCOS Society, an international multidisciplinary society focused on advancing education and awareness, and Verity, a leading patient charity and advocacy group. We established an international steering group with members from across lead agencies, and identified and engaged patient groups and professional societies from the International PCOS Guideline Network, with purposive extension to broader disciplines and world regions.[2] In April, 2025, letters to organisation members were distributed to encourage participation in tasks such as survey dissemination, workshop representative nomination, and contribution to implementation and dissemination of the new name. Building on previous survey results, global surveys were co-designed and disseminated, and international consensus workshops were convened by use of robust methods aligned with the James Lind Alliance processes (panel 2).[17–19]

Delphi surveys

The new surveys built on the results of two previously published surveys and workshops in 2017 and 2023, and were informed by literature review and consultation with health professionals and people with PCOS.[9] We used a purposive, stratified non-probability sampling approach, recruiting participants via partnering professional societies and patient organisations, with targeted

sampling to achieve multidisciplinary representation across world regions. Extended recruitment timelines and dissemination strategies aimed to maximise reach, including engagement with harder-to-reach populations through language translation and use of multiple online platforms. No formal sample size calculation was done; the sample size was guided by our aim of achieving broad global representation across regions and disciplines.

Survey A (appendix p 1) included a historical introduction and rationale, an outline of the mandate for a name change, a linked explanatory statement, ethics approval, and implied consent details. Demographic data included age, country, and participant type (ie, people with PCOS or health professionals). Questions were largely similar across patient and health professional surveys, other than the use of plain language and explanation of technical terms for people with PCOS. Likert scales and free text response options were provided. Additional naming principles included scientific accuracy, ease of communication, stigma avoidance, and cultural appropriateness. Approaches presented included adopting a generic name, an accurate name reflecting features of the condition, or a name that retained the acronym PCOS with different terms. Each proposed approach included a list of terms and name options. The principles, preferred approach, and related options for this approach were carried forward to subsequent stages. Participants could opt to leave their email addresses for future involvement.

Survey A was provided on multiple online platforms (ie, Qualtrics, Google Forms, and WeChat) in English, Chinese, German, Persian, and Malaysian to optimise global reach. These languages were pragmatically selected and provided based on the most common spoken languages globally and the availability of workshop participants for translation, validation, and dissemination. For many other world regions, English proficiency was considered sufficient. All languages were accepted in free text comments. The survey link was disseminated via engaged societies and patient groups (through newsletters, dedicated email communication, and conference announcements), social media (ie, X and LinkedIn), and steering committee networks, and was open from April 1 to Oct 1, 2025. Survey results guided preparatory work for the workshops, including background research on naming options.

Survey B was generated to address specific controversies emerging from workshop A, including the reproductive term and final preferred name (appendix p 15). This survey was disseminated by email to survey A participants who had provided their email address, and to workshop A attendees, and was open from Jan 20 to Jan 31, 2026.

Workshops

Recruitment of attendees was rigorous and purposive, as we aimed for engagement across world regions. People with PCOS included leaders in patient advocacy organisations and community-based participants. Health professionals included representatives from key disciplines and leading world experts. Recruitment sources included members of the steering committee, lead agency governing bodies, and single nominees from each engaged society or patient advocacy group. To engage broadly across world regions and disciplines, additional representatives were identified via networks and self-nomination in survey A. All participants were invited to complete an online expression of interest form on workshop availability, country, ethnicity, nominating organisation, and disciplines; health professionals were also asked about their experience in clinical care for PCOS, and people with PCOS were asked for their time since diagnosis. The steering committee approved the final workshop invitation list, with invitations then sent by email. No financial incentives were offered for participation, other than reimbursement for time and

***Panel 2:* Overview of the consensus process**

We conducted a structured, multistep global process to establish a new name for polycystic ovary syndrome, incorporating patient and professional perspectives across all world regions. Key stages included:

- Funding: we obtained resources for the name change process and translation (in September, 2024)
- Governance and stakeholder engagement: we established an international governance framework and recruited patient organisations, professional societies, and lived experience and multidisciplinary health professional experts (in December, 2024)
- Delphi surveys: building on 7708 previous survey responses, two further global surveys (launched in April, 2025, and January, 2026,) generated a further 14 360 responses from 10 411 patients and 3949 health professionals, that identified principles, approaches, terminology, and combinations for a new name
- Nominal group workshops: in November, 2025, and February, 2026, we held serial online workshops with participants from all world regions for systematic iterative testing of endocrine, metabolic, and reproductive terms, combinations, and acronyms, with prioritisation based on accuracy, acceptability, and cultural appropriateness
- Marketing and communication analysis: we applied branding and communication frameworks to assess feasibility, clarity, and transition strategies for candidate names in December, 2025
- Prioritised outcome: agreement among patients and health professionals on the new name (polyendocrine metabolic ovarian syndrome) occurred in February, 2026
- Implementation strategy: in 2025 and 2026, we developed a transition roadmap to support adoption across clinical practice, research, education, and public communication

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See Online for appendix

contribution from lead patient representatives on the steering committee. Independent observers were recruited and trained to facilitate.

Before workshop A, participants had to complete a code of conduct (appendix p 20) covering expected behaviours, confidentiality, and agreement to respect publication embargo and streamlined communication and messaging with signed agreement. The workshop agenda and a 15-min video presentation on the history of the name change, purpose, workshop processes (including transparent participant recruitment), consensus methods, and participants' roles and responsibilities, were disseminated to all participants. Principles and approaches generated from survey A were presented to underpin the workshop's structure and activities. Preparatory sessions and guiding documents were provided for breakout group chairs (ie, people with PCOS), co-chairs (health professionals), and independent observers. The workshop was conducted via Zoom with dedicated IT support provided by Monash University. Workshop A involved a brief introduction, outline of the code of conduct, presentation of survey results on principles and approaches, and presentations of the most accurate and supported terminology. Participants then engaged in breakout discussions, followed by individual online voting on preferred terms. The process was repeated after combining the terms to form the new name. Breakout groups were preassigned to ensure balanced representation across people with PCOS, disciplines, and world regions. All groups included participants from three to five world regions, three to four people with PCOS, and at least three disciplines. Each group was co-chaired by a patient and a health professional, with independent observers present to oversee adherence to the code of conduct. Each participant had a timed opportunity to raise any clarifications, concerns, or considerations. After breakout discussions, feedback was shared broadly by co-chairs and confidential online individual voting was conducted to rank priorities.

	Survey A (n=3656)	Workshop registrations* (n=60)	Survey B (n=293)
Obstetrics and gynaecology	1183	16	117
Reproductive endocrinology	664	15	94
Endocrinology	366	13	50
Primary care	267	3	36
Nutrition or exercise	215	2	64
Nursing or midwifery	136	2	39
Paediatrics	62	5	17
Dermatology	8	1	2
Psychology	34	1	24
Academia or laboratory work	292	2	81

Questions in surveys A and B were not mandatory, and multiple responses were allowed. Totals therefore might not equal the number of respondents.
*Five participants who attended workshop A were unable to attend workshop B.

Table 1: **Health professional disciplines represented across workshops and surveys A and B**

Patient involvement

Verity, a UK patient charity and advocacy group, led the reinvigoration of the renaming initiative in 2023. The Australian Health Research Alliance guidance on patient involvement was followed throughout the name change process, supporting an active, respectful partnership in which people with PCOS were valued for their lived experience, and were involved as active contributors with shared power.[20] This involvement captured patients' real-world needs and values from global and multicultural perspectives to foster relevant, inclusive, and impactful outcomes. People with PCOS were integrally involved in all stages of governance, survey co-design, workshop development, presentations, dissemination, and communication. Survey results were disaggregated by participant group.

The implementation strategy was co-designed by implementation science experts in partnership with people with PCOS. These were based on the principles derived from survey A, the previous survey's impact assessment,[9] the Consolidated Framework for Implementation Research[21] and the Expert Recommendations for Implementing Change strategies,[22] professional marketing input, and workshop feedback. Ethics approval was obtained from the Monash Health Ethics Committee (project numbers 07070C and 78892).

Outcomes and consensus

The steering group comprised a Chair (ie, author HJT), two people with PCOS (authors RM and LB), and seven multidisciplinary health professionals (authors HJT, JSEL, AEJ, MFC, RJN, AD, and TP) from three continents, and an academic project lead (MBK). The Androgen Excess and PCOS Society Board was an advisory body and included health professionals and academic leaders from multiple world regions and disciplines. Organisations were from across world regions and diverse health professional disciplines, including obstetrics and gynaecology, fertility, endocrinology, paediatrics, dermatology, imaging, primary care, nutrition science, and psychology (appendix p 23).

Survey and workshop reach and participant characteristics

Survey A included responses from 9358 people with PCOS and 3656 health professionals. 27 people with PCOS and 63 health professionals participated in the workshops, and 1053 people with PCOS and 293 health professionals in survey B, with broad global representation (appendix p 24). Given the extensive, multichannel dissemination strategy, a response rate for survey A could not be determined. Health professionals represented a wide range of disciplines (table 1).

Workshop A was held in November, 2025, with 90 attendees from multiple world regions (table 1). Survey B was distributed to participants who had consented to recontact (n=2733), with 1346 responses received (response rate 49%). Participant characteristics for surveys A and B, including age distribution, duration of PCOS in patients, and years of PCOS-related experience among health professionals, are shown in table 2.

	Survey A		Survey B	
	Patients (n=9358)	Health professionals (n=3656)	Patients (n=1053)	Health professionals (n=293)
Age, years				
18–25	1563 (19%)	103 (3%)	116 (11%)	3 (1%)
26–35	4230 (50%)	724 (24%)	461 (44%)	38 (13%)
36–45	1866 (22%)	866 (28%)	292 (28%)	82 (28%)
46–55	523 (6%)	696 (23%)	112 (11%)	93 (32%)
≥56	187 (2%)	612 (20%)	57 (5%)	74 (25%)
Prefer not to say	75 (1%)	47 (2%)	6 (1%)	2 (1%)
Duration of PCOS, years				
<1	1052 (14%)	NA	43 (4%)	NA
1–5	2450 (31%)	NA	299 (31%)	NA
6–10	1564 (20%)	NA	199 (20%)	NA
≥11	2736 (35%)	NA	440 (45%)	NA
PCOS care, years				
≤5	NA	812 (27%)	NA	105 (24%)
6–10	NA	624 (21%)	NA	84 (19%)
11–20	NA	716 (24%)	NA	118 (27%)
>20	NA	845 (28%)	NA	134 (30%)

Percentages are calculated based on available responses for each variable; denominators therefore vary due to non-response. NA=not applicable. PCOS=polycystic ovary syndrome.

Table 2: **Participant characteristics across surveys**

Principles

The guiding principles presented in panel 3 were affirmed in the survey results and endorsed at workshop A (table 3), with most people with PCOS and health professionals supporting the principles. Patient support was strongest for stigma avoidance, and health professionals for accuracy. These principles were carried forward throughout the consensus process (table 3).

Approaches

The approach prioritised on survey was to adopt a new, symptom-based name (as voted for by 86% of people with PCOS and 71% of health professionals). The second ranked approach was adoption of a generic name, such as diabetes or asthma (favoured by 45% of people with PCOS and 54% of health professionals), and the third was retaining PCOS as the acronym (20% of people with PCOS and 40% of health professionals; table 3). This approach was endorsed in workshop A. Prominent themes in the free text comments highlighted long-held patient frustrations over the need for a name that was accurate, enhanced understanding of broader features, and included a focus on recognition that this was a female condition. Some responses noted the need to be aware of implications for individuals of diverse genders. Concerns were also expressed that if no change to the PCOS acronym occurred, the consensus process's impact would be diminished. Based on these results, only the approach for a new, accurate, symptom-based name was explored in the workshops and carried forward in subsequent steps.

Key terms

Survey A's results, presented in table 3, show that endocrine and polyendocrine, metabolic and cardiometabolic, and ovulatory, ovary, and reproductive were terms supported by most participants. In workshop A, after presentation of the survey results, preferred approach, principles, and evidence summaries for accuracy, breakout groups confirmed support for a name change. Only two workshop participants were unsupportive of a name change, citing evolving science related to the genetic component of PCOS, the potential for a male phenotype, and concerns around rebranding and marketing.

Endocrine and metabolic terms were supported; however, consistent concerns arose around the reproductive term. Although accurately aligned to genetics, pathophysiology, and clinical features, the potential for the reproductive term to cause social stigmatisation and harm in some cultures or world regions was recognised. Alternative terms such as ovulatory were felt to be less stigmatising but did not encompass broader reproductive features or extend beyond menopause. Workshop A voting largely aligned with survey A's results, prioritising endocrine and metabolic terms. After discussions, ovulatory was preferred over reproductive, despite concerns that the term could be too narrow.

Panel 3: Summary of naming principles

Principles guiding the development of a new name for polycystic ovary syndrome were established through global Delphi surveys and multistakeholder workshops.

- Support for clinical care, research, and improved health outcomes: the name should facilitate diagnosis, improve awareness, optimise care, and enhance research and understanding of the condition to improve health outcomes
- Scientific and medical accuracy: the name must reflect the underlying endocrine and metabolic pathophysiology and avoid inaccurately including ovarian cysts.
- Clarity and communication: the terminology should be readily understood by patients, clinicians, researchers, and the public
- Avoidance of stigma: terms perceived as potentially stigmatising—particularly those linked directly to reproduction or fertility—should be avoided
- Cultural and linguistic appropriateness: the name must be acceptable and interpretable across diverse cultural, linguistic, and regional contexts.
- Feasibility of implementation: the name should allow for a practical transition in clinical, research, and policy environments

Potential names

In workshop A, the preferred terms were combined into candidate names (table 3) and assessed for duplication, pronunciation, stigma, and cultural implications. Some terms were excluded (eg, metabolic endocrine reproductive syndrome, as its acronym would duplicate that of Middle East respiratory syndrome). Endocrine metabolic ovulatory syndrome, although ranked top initially, was found to overlap with the so-called emo youth subculture, in which emotional expression—particularly melancholy, alienation, romantic despair, and anxiety—was central to identity formation. These issues, along with concerns on the most appropriate reproductive term, precluded consensus on a final new name and highlighted the need for further engagement processes.

	Survey A (April to October, 2025; support %)	Workshop A (November, 2025; ranked first %)*	Survey B (January, 2026; ranked first %)	Workshop B (February, 2026; ranked first %)
Naming principles				
Scientific accuracy	67%	✓	✓	✓
Patients	60%	..	..	..
Health professionals	86%	..	..	..
Ease of communication	68%	✓	✓	✓
Patients	62%	..	..	..
Health professionals	85%	..	..	..
Avoidance of stigma	71%	✓	✓	✓
Patients	66%	..	..	..
Health professionals	85%	..	..	..
Cultural appropriateness	60%	✓	✓	✓
Patients	53%	..	..	..
Health professionals	80%	..	..	..
Naming approaches				
Generic name	48%	NA	NA	NA
Patients	46%	NA	NA	NA
Health professionals	54%	NA	NA	NA
Unchanged PCOS acronym, new terms	25%	NA	NA	NA
Patients	20%	NA	NA	NA
Health professionals	39%	NA	NA	NA
Accurate name	82%	✓	✓	✓
Patients	86%	..	..	..
Health professionals	70%	..	..	..
Key terms				
Endocrine features				
Endocrine	85%	65%	✓	NA
Patients	89%	NA	..	NA
Health professionals	74%	NA	..	NA
Polyendocrine	81%	35%	NA	✓
Patients	88%	NA	NA	..
Health professionals	60%	NA	NA	..
Metabolic features				
Cardiometabolic	52%	21%	NA	NA
Patients	52%	NA	NA	NA

(Table 3 continues on next page)

Additional steps

Review of all survey responses and breakout discussions, and reconsideration of alternative terms with majority support, highlighted polyendocrine and ovarian as potential alternative terms. Pro bono assessment from leading experts in a global marketing agency, including the use of artificial intelligence marketing, did not identify any additional terms or names beyond those already considered. The recommendation was for evolutionary rebranding—which supports some continuity with an existing name or acronym and is framed as an update—rather than revolutionary rebranding, which implies a new condition. Survey B in January, 2026, yielded 1346 responses (from 1053 people with PCOS and 293 health professionals) from across all world regions. Terms presented included ovary and ovulatory, with ovulatory ranking the highest on surveys (table 3); thematic analysis of free text responses confirmed limitations of these terms, with incomplete representation of ovarian, endocrine, and follicular disturbances, and irrelevance after menopause. Polyendocrine was included as an option, alongside endocrine, based on majority support from survey A, workshop concerns on the cultural implications of the acronym EMOS, and because it offered an evolutionary marketing approach with similarity to the current acronym, PCOS. Workshop B presentations and breakout groups reviewed all survey results and free text comments for ovary-related terms (ie, ovulatory and ovary from survey A, and ovarian from previous surveys, with 62% of people with PCOS and 67% of health professionals supporting the latter on surveys). Ultimately, workshop voting prioritised ovarian (encompassing endocrine, follicular, and ovulatory disturbances), over ovary or ovulatory.

New name

The top ranked name on survey B was polyendocrine metabolic ovulatory syndrome. Workshop B revised this to polyendocrine metabolic ovarian syndrome. All participants supported the new name, except for two participants who also did not support a name change. The need for careful attention in language translation was also captured.

Implementation

The co-designed implementation strategy was presented and discussed in workshop breakout groups. Individual feedback was collected from breakout groups and in live online surveys to finalise the strategy (panel 4).

Implications

This unprecedented and comprehensive international health policy initiative was ultimately focused on

implementation for global-level impact. The robust process generated representativeness, legitimacy, and transparency, with engagement of people with PCOS, health professionals, and 56 organisations across world regions. Building on a mandate for change, 14 360 survey responses and multiple workshops with around 90 representatives generated agreed principles, supporting better outcomes for people with PCOS, scientific accuracy, ease of communication, avoidance of stigma, cultural appropriateness, and optimising implementation. The preferred approach was evolution to a new accurate name that retained some similarity to PCOS to enable its implementation. Ultimately, prioritised terms were polyendocrine, metabolic, and ovarian, and the preferred name for the condition formerly known as PCOS was polyendocrine metabolic ovarian syndrome (PMOS). An implementation strategy was codeveloped and is under way.

A clear rationale and mandate for change underpinned this consensus process.[9] The need to correct the inaccurate polycystic term (which implies pathological ovarian cysts)[10] and recognise the multisystem features of the condition[2] were prioritised by patient and health professional groups. and government agencies.[14] Widespread delayed diagnosis, knowledge gaps, and patient dissatisfaction with information provision and care, are well documented.[9,12,13] Although International Guidelines, evidence-based resources, and ongoing patient and health professional advocacy have contributed to improved awareness, confusion associated with the name has persisted, reinforcing the mandate for change (panel 1).[9] Renaming a medical condition is a complex process that requires funding, governance, broad engagement, and adherence to robust methods and processes. Such a change also necessitates stakeholder engagement to ensure representativeness, legitimacy, and transparency, and to optimise implementation.[9] Throughout this process, we built on a clear mandate for change, secured funding, established leadership and governance, delivered a coordinated global consensus process, obtained broad and inclusive engagement between people with PCOS and multidisciplinary health professionals, and achieved agreement on principles and approaches. We applied iterative Delphi surveys and nominal group workshop techniques that were linked to a robust implementation strategy.[17,18,20–22] This approach addressed barriers and surpassed previous stalled renaming attempts to exemplify an inclusive, iterative process that could help guide future name change initiatives.

PMOS encompasses multiple interacting endocrine abnormalities, rather than an isolated ovarian disorder.[5,23–25] Meta-analyses of large-scale genomic analyses and recent definitive studies confirm that PMOS has polygenic origins across neuroendocrine, metabolic, and reproductive pathways.[26,27] Hyperandrogenism is a defining endocrine and diagnostic feature, with elevated ovarian—and often adrenal—androgens contributing to hirsutism, acne, alopecia, and metabolic features.[2,28,29] Central neuroendocrine abnormalities include increased gonadotropin-releasing hormone pulsatility, with consequent elevations in luteinising hormone that drive

	Survey A (April to October, 2025; support %)	Workshop A (November, 2025; ranked first %)*	Survey B (January, 2026; ranked first %)	Workshop B (February, 2026; ranked first %)
(Continued from previous page)				
Health professionals	52%	NA	NA	NA
Metabolic	76%	79%	✓	✓
Patients	74%	NA	..	..
Health professionals	80%	NA	..	..
Reproductive features				
Reproductive	54%	40%	NA	NA
Patients	52%	NA	NA	NA
Health professionals	63%	NA	NA	NA
Ovary	42%	NA	NA	25%
Patients	38%	NA	NA	8%
Health professionals	53%	NA	NA	30%
Ovulatory	54%	60%	51%	5%
Patients	51%	NA	49%	8%
Health professionals	64%	NA	64%	5%
Gynaecological	NA	NA	37%	NA
Patients	NA	NA	40%	NA
Health professionals	NA	NA	27%	NA
Repro†	NA	NA	13%	NA
Patients	NA	NA	11%	NA
Health professionals	NA	NA	9%	NA
Ovarian	NA	NA	NA	70%
Patients	NA	NA	NA	85%
Health professionals	NA	NA	NA	65%
Names and acronyms for combination of terms				
Endocrine metabolic ovulatory syndrome	NA	NA	22%	NA
Patients	NA	NA	22%	NA
Health professionals	NA	NA	24%	NA
Ovulatory metabolic endocrine syndrome	NA	NA	11%	NA
Patients	NA	NA	10%	NA
Health professionals	NA	NA	19%	NA
Polyendocrine metabolic ovarian syndrome‡	NA	NA	66%	✓
Patients	NA	NA	69%	..
Health professionals	NA	NA	57%	..

Tick marks indicate the option was prioritised and carried forward to the next stage of the consensus process. NA=not assessed. *Ranked first indicates the percentage of respondents who selected the option as their highest-ranked (most preferred) choice. †Repro was provided as an option for reproductive, with examples including repro-endocrine or repro-metabolic. ‡Polyendocrine metabolic ovarian syndrome was substituted for endocrine metabolic ovulatory syndrome given its majority support in survey A workshop A, marketing recommendations and cultural considerations, and to address challenges associated with the acronym of endocrine metabolic ovulatory syndrome (EMOS). PCOS=polycystic ovary syndrome.

Table 3: **Iterative development of naming components across surveys and workshops**

Panel 4: **Eight stages for global implementation of the new name for polycystic ovary syndrome, polyendocrine metabolic ovarian syndrome**

The implementation strategy was informed by considerations highlighted in survey responses, and was co-designed with consumers, marketing and implementation experts, and governance bodies (including health professional experts), and was based on implementation science frameworks.

Stage 1: publication and academic dissemination
Publication of this Health Policy, supported by accompanying commentaries, clinical reviews, editorial correspondence, and updates to textbooks and educational materials.

Stage 2: resource development
Co-design of patient and health professional resources in multiple languages and for diverse platforms and delivery modes.

Stage 3: global communication and engagement
Implementation of a structured communication strategy, including society toolkits, multilingual patient and clinician resources, multimedia dissemination, professional education programmes, and coordinated events for patients and health professionals worldwide.

Stage 4: integration within health care and health information systems
Incorporation of the new terminology into electronic health records, including within Systematized Nomenclature of Medicine—Clinical Terms, and engagement with major electronic medical record vendors and key stakeholders in health-care provider education (eg, universities and textbook publishers).

Stage 5: policy and research alignment
Engagement with governments, research funders, journal editors, regulators, and the health-care industry (including the pharmaceutical industry), to support adoption across research classifications, publication processes, and funding systems.

Stage 6: international classification and global bodies
Formal engagement with international bodies, including WHO, to progress integration into disease classification systems, including the ICD.

Stage 7: transition and future refinement
A managed transition period of 3 years with monitoring and evaluation, consideration of emerging evidence on subtypes, and refinement of terminology as scientific understanding evolves.

Stage 8: guidelines
Integration into the International Guideline, which is already used in 195 countries and will next be updated in 2028.

excessive ovarian androgen.[24] Insulin resistance and compensatory hyperinsulinaemia, present in 85% of affected individuals (75% of lean women [with BMI ≤25 kg/m²] with PMOS),[30,31] amplify androgen secretion and disrupt steroidogenesis, highlighting the metabolic–endocrine interplay.[30,31] Altered AMH concentrations, ovarian endocrine function, adipokine signalling, and gut–hormone interactions influence clinical features, including reproductive and metabolic manifestations.[5,32] Furthermore, the combination of endocrine disturbances underpin pregnancy risks, which are compounded by metabolic features.[33,34] Collectively, these complex endocrine abnormalities underscore the multisystem manifestations of PMOS and support reframing it as a polyendocrine condition that extends beyond ovarian pathology.

Metabolic abnormalities underpin PMOS, from genetic origins to clinical manifestations.[2,5,26,35] Insulin resistance affects the majority of people with PMOS and contributes to androgen excess, which, together with low-grade inflammation and dysfunctions in adipokine signalling and the sympathetic nervous system, drives metabolic dysfunction.[5,36] Obesity—particularly central adiposity—is increased in people with PMOS, implicated as causal on mendelian randomisation studies, and exacerbates symptom severity.[2,37] Lifestyle, pharmacological, and surgical weight management interventions have shown clinical benefit.[37–40] Cardiometabolic complications, such as impaired glucose tolerance, gestational diabetes, metabolic dysfunction-associated steatotic liver disease, type 2 diabetes, dyslipidaemia, hypertension, and vascular dysfunction are increased in PMOS, exacerbated by obesity, and drive cardiovascular disease risk.[2,5,35,41,42] Evidence from women who are predominantly premenopausal shows that the odds ratios of composite cardiovascular disease (1·68), myocardial infarction (2·50), and stroke (1·71) are increased in those with PMOS compared with those without PMOS.[43] Collectively, this evidence shows that metabolic features are inherent in PMOS, which firmly endorses incorporation of the metabolic term in the revised nomenclature.

Ovarian dysfunction is a defining feature of PMOS, with genetic origins and disturbances in endocrine and paracrine function during and beyond reproductive life stages.[5] Neuroendocrine abnormalities disrupt ovarian steroidogenesis and impair follicular maturation. Such dysfunction is exacerbated by hyperinsulinaemia-driven dysregulation of granulosa and theca cells, which worsens hyperandrogenism.[5] These abnormalities disrupt folliculogenesis and result in accumulation of small antral follicles, as seen in the classic ultrasonographic appearance of this condition.[44] Elevated AMH occurs with disordered folliculogenesis, and is now included in adult diagnostic criteria.[2,32] Clinically, these abnormalities manifest as ovulatory dysfunction, menstrual irregularity, and infertility, endorsing the explicit inclusion of ovarian in the new nomenclature. Other features of the condition, such as psychological and dermatological changes, are important but are largely secondary to endocrine changes, and these terms were not supported for inclusion in the new name.[9]

The implementation strategy for the new name was generated through use of a structured, co-designed process grounded in the Consolidated Framework for Implementation Research and Expert Recommendations for Implementing Change.[21,22] Led by implementation experts and informed by implementation priorities identified from the surveys and workshops outlined here,[9] patients' and health professionals' input, and marketing specialists, the multistage global implementation strategy aids transition to the new name

and incorporates evaluation (panel 4). This strategy includes: publication and academic dissemination; development of multilingual resources for people with PCOS and clinicians; coordinated global communication and engagement; integration into electronic health records and health-care education systems; alignment with policy agencies, research funders, and journal processes; formal engagement with international classification bodies, including WHO, for adoption in the ICD; and a managed 3-year transition and planned integration into the 2028 update of the International Guidelines, which are already used in 195 countries.[2] This implementation strategy is supported by an embedded evaluation plan. Key considerations include meaningful language translation and cultural appropriateness, especially where reproductive implications and infertility can be linked to the supposed value or worth of an affected individual. This approach creates the implementation architecture to support consistent global uptake of the new name for sustainable change across policy, research, health systems, practice, and outcomes.

This Health Policy initiative has both strengths and limitations. A major strength is the unprecedented partnership and involvement with stakeholders (ie, people with PCOS and health professionals) across all stages, including governance, conceptualisation, co-design, recruitment, interpretation of results, participation in consensus workshops, and implementation. Robust consensus methods were applied. The consensus process presents an exemplar to overcome barriers in name change processes as scientific understanding evolves. Limitations of this Health Policy initiative include disproportionate representation across world regions and disciplines, with lower participation from middle-income and low-income countries, and from Asia, Africa, and South America. Furthermore, the use of a purposive, non-probability sampling approach and voluntary participation could introduce selection bias and hinder generalisability. In addition, response rates could not be determined for survey A due to broad dissemination. Despite these limitations, analysis of survey results by region did not identify major differences in the final terms or name preferences. The overwhelming majority of participants in earlier surveys and workshops supported a name change, and the principles, approach, and terms used.

Conclusion

In this common yet historically neglected female condition affecting more than 170 million individuals worldwide, we led global engagement of people with PCOS and health professionals through a structured, multistep, robust process to generate a new name that avoids misleading references to ovarian cysts and accurately reflects the condition's diverse and multisystem features. The condition formerly known as PCOS now has a new name: polyendocrine metabolic ovarian syndrome. This change has global implications for health-care systems, policy, and research, and for advancing understanding and treatment of the condition. Transition to the new name will occur over 3 years, supported by a multifaceted implementation strategy. Overall goals include greater awareness, enhanced diagnosis, improved care quality and patient satisfaction, and optimised outcomes across the broad features of the condition. The transition is underpinned by a global implementation and embedded evaluation strategy.

Contributors

HJT is the lead investigator and led this Health Policy initiative from funding to conception, engagement, analysis, interpretation, and drafting the publication. AEJ, RJN, and MFC are investigators of the Centre for Research Excellence in Women's Health in Reproductive Life. Authors included members of the Steering Committee and Androgen Excess and Polycystic Ovary Syndrome Society Board who contributed to the concept, design, governance, and completion of this Health Policy. HJT, MBK, and RM led survey development, dissemination, and analysis, and workshop design and analysis. All named authors and those in the international network (appendix pp 25–27) engaged in the surveys and workshops, could access the data on request, and contributed to data interpretation in the workshops, and to editing and revising the manuscript. All authors had final responsibility for the decision to submit for publication, and all provided their approval for submission.

Declaration of interests

HJT is the primary investigator of the Australian National Health and Medical Research Council (NHMRC)-funded Centre for Research Excellence in Women's Health in Reproductive Life (APP number 1171592), and is supported by an NHMRC Fellowship (APP number 2009326). She is the unpaid President of the International Society of Endocrinology and lead on the International Polycystic Ovary Syndrome Guidelines and the National Institute for Health and Care Excellence (NICE) Guidelines Committee. RM has received grants from Waterloo Foundation and Verity for administrative support, the James Lind Alliance Priority Setting Partnership, and the All-Party Parliamentary Group. She has received support from Roche Pharmaceutical for travel and time to film patient story videos. She is an unpaid Trustee of Verity and a member of the International Guidelines Steering Group and the NICE Guidelines Committee (honoraria). JSEL has received grants and personal fees from Astellas, Ferring, Gedeon Richter, and Siemens. He is a member of the Androgen Excess and Polycystic Ovary Syndrome (AE-PCOS) Society Board and a member of the Data Safety Monitoring Board of the LOCI trial. He is the Chief Executive Officer and owner of JSEL Consultancy. AEJ has received honoraria from Amgen, Novo Nordisk, and Eli Lilly for presentations. She served on the Board of Directors of the AE-PCOS Society and has received free continuous glucose monitoring devices (ie, Freestyle Libre, Dexcom G7, and OnePlus) for research or clinical purposes. DAR is the Chair of the steering committee for the LOCI trial, a topic adviser for the NICE Guideline Committee, a board member of the AE-PCOS Society, and participates in the All-Party Parliamentary Group on Polycystic Ovary Syndrome. RJN reports support from the Centre for Research Excellence in Women's Health in Reproductive Life, consulting fees from Westmead Fertility and VinMec Hospital, is Chair of the Data Safety Monitoring Board for a Chinese natural therapies and miscarriage study (NCT02633878), and is Chair of the Clinical Advisory Committee at Westmead Fertility. AD serves as Executive Director of the AE-PCOS Society. TP has received project grants from Novo Nordisk, the Research Council of Finland, and the Sigrid Juselius Foundation; consulting fees from Exeltis and Astellas; honoraria from Exeltis, Gedeon Richter, Stragen, and Bayer; and travel support from Gedeon Richter. She is the unpaid President of the AE-PCOS Society. All other authors declare no competing interests.

Data sharing

We can share de-identified, individual participant-level survey data once all analyses are completed and after receipt of a request detailing the study hypothesis and statistical analysis plan. All requests should be sent

to the corresponding author (helena.teede@monash.edu). The steering committee of this study will discuss all requests and decide, based on the scientific rigour of the proposal, whether data sharing is appropriate. All applicants will be asked to sign a data access agreement.

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